STATE OF VERMONT

HUMAN SERVICES BOARD

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| In re | ) | Fair Hearing No. 18,319 |
| | ) | |
| Appeal of | ) | |

## INTRODUCTION

The petitioner appeals a decision by the Department of Aging and Independent Living (DAIL) substantiating a report of neglect by the petitioner involving a vulnerable adult who was a resident in a Level IV residential care home operated by the petitioner.

## PROCEDURAL HISTORY

The petitioner filed her request for fair hearing on February 18, 2003 appealing a decision by DAIL finding licensing violations at the residential care home she operated.[1] On April 18, 2003, a Commissioner's Review was completed upholding several of the licensing violations and finding that the petitioner had neglected a vulnerable adult residing in her residential care home. The neglect finding related to events comprising said licensing violations and to a complaint that Adult Protective Service had substantiated.

[1] The petitioner is no longer operating the residential care home.

As a result of the Commissioner's review, both the licensure and neglect issues came before the Human Services Board.

A fair hearing was originally scheduled for June 20, 2003 and continued to July 1, 2003. That hearing was continued by agreement of the parties. During 2003, DAIL filed an action in Chittenden Superior Court, *State of Vermont v. B.R.*, Docket No. S0979-03CnC dealing with issues arising from the underlying allegations in this case. As a result of the pending Superior Court action, this case has been continued with the understanding that the parties would contact the Human Services Board to schedule a hearing, if needed. The Human Services Board followed up annually to determine whether the case should be continued. In response to the Board notification of May 22, 2006, the neglect issue was reactivated and a fair hearing was then scheduled. The licensure issues remain in Superior Court.

A fair hearing was held October 23, 2006. Briefing was completed by December 29, 2006. The decision is based upon the evidence adduced at hearing.

FINDINGS OF FACT

1. The petitioner operated a Level IV residential care home located at [address]. Petitioner received her license to operate a Level IV residential care home in 1982.

2. J.M.[2] was a resident at the residential care home during the December 2002 events that form the basis of the complaints brought against the petitioner. J.M. first came to petitioner's residential care home from Vermont State Hospital. J.M. was seventy-seven years old at the time of the incident. Prior to the incident, J.M.'s medications included both heart medications and psychotropic medications.

3. A 911 call for emergency assistance was made on December 3, 2002 at 2:46 a.m. T.M. was part of the crew that responded to the call from [address].

4. T.M. is an Assistant Fire Marshall for the City of Burlington. T.M. has worked for the Burlington Fire Department for eleven years. T.M. has been an EMT (emergency medical technician) for eighteen years and was certified as an EMT Intermediate in 2003. In addition, T.M. has been a registered nurse (R.N.) since 1999 specializing in emergency room medicine. T.M. works part-time as a R.N.; his present job is in the emergency room at Central Vermont Hospital.

[2] J.M. is now deceased.

5. Both an ambulance and a fire engine were dispatched to the emergency call. Both vehicles had their lights flashing. A total of four people responded to the 911 emergency call. T.M. was the crew chief of the ambulance. As crew chief, T.M.'s primary responsibility was to care for the patient. Subsequent to completing the call, T.M. completed the Vermont EMS Incident Reporting System form.

6. T.M. arrived at [address] at 2:51 a.m. The crew was met by a man standing at the curb and waving his arms. The man, M.C., was another resident of the petitioner's residential care home. M.C. took T.M. and the other crew members to J.M. J.M. was in a second floor bedroom. T.M. described finding the building dark. Only the light on the stairs was on.

7. When T.M. arrived in the room, T.M. found J.M. in bed. J.M. was unable to sit up. J.M. was short of breath, wheezing with rapid and shallow breathing. His respirations were twenty-eight per minute; his pulse was ninety-six per minute. J.M. was so short of breath that he could only answer T.M.'s questions one word at a time. T.M. noted that J.M.'s neck muscles and veins were swollen. J.M. became weak and dizzy upon standing due to dropping blood pressure. There was venous distortion in the jugular veins. T.M.

testified that J.M. reported being short of breath all day. T.M. asked J.M. about his last meal; EMTs ask for this information as part of gathering information for medical providers. J.M. reported staying in his room without meals the previous day.

8. T.M. explained that when a person has struggled for breath for a period of time, the diaphragm becomes tired and chest and neck muscles are used to compensate or assist in breathing. Swollen neck muscles are a sign of strained breathing. Swollen neck veins are a sign that the heart is not able to pump blood efficiently. Normal respiration is twelve to sixteen. Part of his duties is to assess the patient's symptoms. Based on his observations of J.M. and his experience, T.M. concluded that J.M. had been ill for the previous day and had been having difficulty breathing for some time. T.M. testified that J.M.'s symptoms were consistent with gradual onset. T.M. found that J.M. was suffering from heart failure.

9. T.M. attempted to obtain information from J.M. about his medical history and medications. EMTs try to obtain as much information as possible regarding medications and medical history to provide to the emergency room staff. T.M. did not find any information regarding J.M.'s

medications or history. M.C. was unable to give any information. T.M. had his crew try to find a staff member who could provide information about J.M.'s medications and medical history. The crew was unable to find a staff member.

10. The crew moved J.M. from his room. They used a stair chair to move J.M. to the first floor when they transferred him to a stretcher. They left the residential care home at 3:06 a.m. They determined that the transport was a Code three transport; Code three transport is for the seriously ill and means that sirens are used. T.M. said they used their sirens when they departed from the residential care home.

11. During the time T.M. and his crew were in the residential care home, they kept on the flashing lights of the ambulance and fire engine which were parked outside the residential care home on [address]. No staff appeared during this time. T.M. testified that he heard no other noises but the noises he and his crew made. They made no efforts to be quiet.

12. T.M. had no direct recollection whether he transported J.M.'s medications to the hospital. T.M. did not note any medications on the Vermont EMS Incident Reporting System form. T.M.'s practice is to note medications on the

EMS Incident Reporting Form. T.M. stated that the lack of any notation of medications meant that he did not take J.M.'s medications to the hospital.

13. T.M. reported to the emergency room doctor that he believed J.M. to be a victim of neglect because he had concerns about J.M.'s untreated heart condition, that J.M.'s breathing difficulties should have been evident to staff, that staff did not notice J.M. had remained in his room and missed meals during the previous day, and that staff were not available during the emergency call. As a mandated reporter, T.M. made a report to Adult Protective Services.

14. J.M. was discharged from Fletcher Allen Medical Center (FAHC) on December 7, 2002. His diagnosis was congestive heart failure. The attending physician ordered physical therapy. Physical therapy did not occur. J.M. was given five new prescriptions to fill. These prescriptions included Ecasa (aspirin), Hydralazine, Artorastatin (lipitor), Epoctin, and nicotine transdermal patch. These prescriptions were not filled except for hydralazine on December 17, 2002.

15. From December 7 to December 9, 2002, J.M. did not have his medication tray. There is no evidence that the medication tray was taken to the hospital on December 3, 2002

so that it is not clear where the tray was during the period J.M. was hospitalized. However, J.M. had access to the medications prescribed prior to his hospitalization since he had vials containing the medications.

16. On December 9, 2002, the petitioner took J.M. to the emergency room at FAHC because J.M. was having trouble breathing and he did not have medication.

17. On December 9, 2002, petitioner was contacted by the Visiting Nurse Association (VNA) regarding the order for J.M.'s physical therapy. The VNA wanted to schedule a time for an evaluation. Petitioner told the VNA that J.M. had returned to the hospital. Petitioner agreed to contact the VNA upon J.M.'s return from the hospital. J.M. returned from the hospital that same day, but petitioner did not contact the VNA at that time. J.M. did not receive physical therapy. There is no indication that the physician's order for physical therapy was cancelled.

18. The Division of Licensing and Protection, Adult Protective Services assigned S.P. to investigate the report of neglect.

19. S.P. is a nurse surveyor for DAIL, Division of Licensing and Protection. S.P. has been certified as a nurse surveyor since 1990. Her duties include the identification

and investigation of complaints of abuse, neglect and exploitation of vulnerable adults. S.P. has been a registered nurse (R.N.) licensed to practice in Vermont since 1976.

20. S.P. went to the residential care home on December 16 and 18, 2002. As part of her investigation, she interviewed petitioner and two residents (J.M. and M.C.) at the residential care home; interviewed T.M., [doctor] (J.M.' primary care physician), [Nurse] of the VNA, [J.M. pharmacist] and petitioner's husband; did a records review and follow-up with the pharmacy.

21. S.P. takes contemporaneous notes when she conducts interviews during an investigation and did so as part of this investigation. S.P. noted a variety of accounts from petitioner about her whereabouts the night J.M. was taken to FAHC by the Burlington Fire Department. S.P.'s notes included the following information from petitioner:

> Went to JM/s room @ 2:30 a.m.—in bed asleep. I went and showered. [M.C.] called 911 while in shower/getting dressed. [M.C.] had seen me but never said anything.

S.P. was told by petitioner that petitioner was asleep in the pool room[3] and did not hear anyone knocking on her door or hear the EMT crew walking around, that petitioner was in the shower and did not hear anything, that petitioner was getting clothes from 411, and that petitioner may have been grocery shopping.

22. S.P. testified that J.M. said that his heart was pounding and that he tried to get to petitioner's room for help but there was a bar on the door. No one responded to J.M.'s knocking. At that point, he went to M.C. for help. There are bars on the pool room door.

23. M.C. told S.P. that he knocked on the door of the pool room but no one answered. He then called 911.

24. On December 16, 2002, S.P. reviewed the patient instruction sheet provided to J.M. upon his release from FAHC on December 7, 2002. The patient instruction sheet contained the list of medications. Between the time S.P. first saw the patient instruction sheet and the time petitioner presented the patient instruction sheet at the Internal Dispute

[3] The pool room is on the first floor and is between [address]. Petitioner operates 411 as a boarding home. The pool room and the petitioner's bedroom are separate spaces. At times, petitioner slept in the pool room. On the night in question, petitioner was sleeping in the pool room.

Resolution with DAIL, handwritten notes and lines through some of the medications had been added.

25. When S.P. visited the residential care home on December 16, 2002, the original prescriptions were still in the facility's possession. These prescriptions had not been filled (the prescription for Hydralizine would be filled the next day). Between the time S.P. first saw the prescriptions and the time the petitioner presented the prescriptions at the Internal Dispute Resolution, the prescriptions were altered with a line drawn through the word "one" on the refill section.

26. When S.P. was at the residential care home on December 18, 2002, petitioner was summoned by a resident to help J.M. get out of the bathtub because he was too weak to do so by himself.

27. At the conclusion of the investigation, S.P. prepared a Statement of Deficiencies. The findings relative to neglect are found on pages 1 through 4, 7, 8, 12 and 13. S.P. concluded that petitioner neglected J.M. because petitioner failed to ensure J.M. received necessary services including the ordered physical therapy and filling of the new prescriptions.

28. In addition, S.P. prepared a Memorandum to V.L., Program Chief of Adult Protective Services. S.P. recommended substantiation of neglect for failure to:

(1) obtain prescriptions upon J.M.'s release from FAHC,

(2) assure that physical therapy services were provided,

(3) assure that medications were documented including monitoring of side effects for psychotropic drugs,

(4) assure there was sufficient staff to provide appropriate care in an emergency, and

(5) assure that J.M.'s plan of care included nursing oversight.

S.P. did not recommend substantiation for failure to intervene on December 2 and 3, 2002. However, as a part of the Commissioner's Review, Commissioner Patrick Flood added the failure to intervene to the other areas of neglect.

29. Petitioner testified at the fair hearing. Petitioner testified that she brought J.M. his breakfast during the morning of December 2, 2002. Petitioner testified that she offered J.M. lunch and dinner which he did not accept. Petitioner stated that she last saw petitioner that night at 9:00 p.m. Petitioner testified that J.M. appeared fine and that he had no problem breathing on December 2, 2002. Petitioner's statement about when she last saw J.M. contradicts her earlier statement to S.P. that she saw J.M.

at 2:30 a.m. December 3, 2002 and that he was asleep. She testified that she meant to check on J.M. at 2:30 a.m. but did not do so as she was unable to walk up the stairs due to her asthma. Petitioner testified that she did a daily check of the residents every night between 2:00 to 3:00 a.m. Due to her asthma, she decided to shower at approximately 2:30 a.m. Petitioner did not do her daily check after her shower.

30. Petitioner testified that she was sleeping in the pool room the night of December 3, 2002. She testified that she was a light sleeper waking both for noises or flashing emergency vehicle lights that passed her home. She did not believe M.C. knocked because she did not hear him. Petitioner testified that she went into the bathroom under the stairs, took a shower and used a blow dryer for her hair and that she must have been there during the emergency call. Petitioner also testified that she heard loud footsteps coming down the stairway when she was in the bathroom but thought the noise was caused by residents. She did not investigate the noise. Petitioner further testified that when she came out of the shower she saw the red lights and thought someone had called an ambulance. She did not look out at [road] (the direction of the lights) but looked out at [avenue] where no emergency vehicles were parked. She did

not investigate whether the ambulance was for a resident at her facility. Given the commotion on the stairs and the flashing red lights, the reasonable response would be to investigate and determine whether any of her residents were involved.

31. Petitioner testified that the lights were on in the living room, bathroom, stairs and halls on December 3, 2002. Petitioner's testimony contradicts T.M.'s testimony that only a hall light was on. I find T.M.'s testimony regarding the lighting conditions he found on December 3, 2002 to be more credible than petitioner's testimony.

32. J.M. returned from FAHC on December 7, 2002. Petitioner had not been told J.M. was returning. Petitioner testified that J.M. came down the stairs and then testified that J.M. came through the front door.

33. Petitioner's testimony regarding J.M.'s prescriptions was confused. She saw the new prescriptions when J.M. returned on December 7, 2002. She testified she did not handle prescriptions and that she thought all his prescriptions were called into the pharmacy. She did not know what some of the medications were for so she looked them up. Petitioner testified that she spoke to a doctor at FAHC to find out about the medications and called the VNA about

the injection prescribed for J.M. Her actions were inconsistent with her statement that she had no involvement with medications.

34. At some point, she learned he was not taking his new medications. It should be noted that petitioner took J.M. to the emergency room at FAHC on December 9, 2002 because he was out of breath and out of medications[4]. Petitioner's testimony at the hearing and S.P's reports on her interviews are consistent that J.M. was out of breath. The accounts differ in that S.P. reported petitioner said J.M. was out of medications and petitioner testified that J.M. did not have the new medications.

35. Ordinarily, J.M. used a pill tray. J.M. did not have his pill tray after he returned from FAHC on December 7, 2002. There is no indication that the EMTs took the pill tray to FAHC on December 3, 2002. Petitioner testified that she believed the pill tray was taken to FAHC on December 3, 2002 but not returned on December 7, 2002. She testified that the pill tray was returned to J.M. when he went to the emergency room at FAHC on December 9, 2002. It is hard to credit petitioner's theory that the Emergency Room staff

[4] Based on the print-out from [pharmacy], a number of J.M.'s prescriptions pre-dating his December 3, 2002 hospitalization were filled on December 10, 2002 and delivered on December 11, 2002 by the pharmacy.

would keep a pill tray for a week and be able to return the tray to J.M..

36. M.M. testified on petitioner's behalf. M.M. is petitioner's daughter. She volunteered at the residential care home the weekend of December 7, 2002. She did not see J.M. take any medications that weekend.

37. Petitioner and M.M. believe that S.P. misunderstood petitioner during S.P's interviews with petitioner and mistakenly reported inconsistencies in petitioner's accounts because S.P. wears a hearing aid. M.M. is supporting her mother and her testimony needs to be seen in that light. Based on the demeanor of S.P. and petitioner as well as the quality of their testimony, I do not find this supposition credible. Petitioner's testimony at hearing included inconsistencies and nonresponsive answers; the tenor of petitioner's is consistent with the differing responses found in S.P.'s report and testimony.

## ORDER

The Department's decision is affirmed.

## REASONS

The Commissioner of DAIL is required by statute to investigate reports regarding the neglect of vulnerable

adults. 33 V.S.A. § 6906. DAIL is required to keep reports that are substantiated in a registry under the name of the person who committed the neglect. 33 V.S.A. § 6911(b). Persons who are found to have committed neglect may apply to the Human Services Board for relief on the grounds that the report in question is "unsubstantiated". 33 V.S.A. § 6906(d).

Neglect has been defined in 33 V.S.A. § 6902(7) as follows:

> Neglect means purposeful or reckless failure or omission by a caregiver to:
>
> > (A)(i) provide care or arrange, and for goods or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to food, clothing, medicine, shelter, supervision, and medical services, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or a terminal care document, as defined in subchapter 2 of chapter 111 of Title 18.
> >
> > . . .
> >
> > (B) Neglect may be the repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm, as a result of subdivisions (A)(i). . .of this subdivision (7).

J.M. met the definition of a vulnerable adult who is to be protected from neglect. At the time in question, J.M. was a "person eighteen years or older who: (A) [was] a resident

of a facility required to be licensed under chapter 71 of this title". 33 V.S.A. § 6902(14)(A). Petitioner's residential care home was a facility licensed under chapter 71.

To better understand whether petitioner's actions constitute neglect, we need to look at petitioner's responsibilities as an operator of a Level IV residential care home.

Residential care home is defined in 33 V.S.A. § 7102(1) as follows:

> (1) "Residential care home" means a place, however named, excluding a licensed foster home, which provides, for profit or otherwise, room, board and personal care to three or more residents unrelated to the home operator. Residential care homes shall be divided into two groups, depending upon the level of care they provide, as follows:
>
> (A) Level III, which provides personal care, defined as assistance with meals, dressing, movement, bathing, grooming, or other personal needs, or general supervision of physical or mental well-being, including nursing overview and medication management as defined by the licensing agency by rule, but not full-time nursing care; and
>
> (B) Level IV, which provides personal care, as described in subdivision (A), or general supervision of the physical or mental well-being of residents, including medication management as defined by the licensing agency by rule, but not other nursing care;

In addition as a caregiver, petitioner's duties include providing subsistence or medical care. 33 V.S.A. § 6902(2).

DAIL has developed regulations governing residential care homes including the requirements that the resident's needs are met including arranging medical care needs and ensuring that the resident's medication services are consistent with doctor's orders, and having sufficient staff available at all times to meet emergency needs. Licensing Regulations of Residential Care Homes. See sections 5.5 (general care) and 5.11 (staff services). An operator of a Level IV residential care home need not have staff stay awake during the night, but needs to make sure that staff is on site and available if an emergency occurs.

Petitioner supplied an array of explanations why she was not available the early morning hours of December 3, 2002. Whatever the actual facts were regarding petitioner's whereabouts, the fact is that petitioner was not available and did not have someone else available when J.M.'s emergency arose. No staff member was available to assist J.M. or to give the emergency crew needed information about J.M.' health history or his medications. The flashing lights and the noise the emergency crew made looking for a staff member and then transporting J.M. from the second floor to the ambulance

should have been sufficient to put petitioner on notice to investigate whether any of her residents was involved.

Moreover, petitioner should have been aware of J.M.'s difficulties breathing and feeling poorly on December 2, 2002. T.M.'s testimony painted a picture of a man in distress—shortness of breath, weakness, distention of neck muscles and veins. J.M.'s symptoms pointed to a man who had been exhibiting symptoms prior to the 911 call.

In petitioner's post-hearing brief, petitioner objects to the use of T.M.'s testimony as expert testimony. However, no objection was made at hearing.

Further, as an EMT and emergency room nurse, T.M. is trained to make clinical assessments to ascertain the level of emergency, information to be provided to the emergency room doctors, and as an EMT, the level of response while transporting a patient to the emergency room. T.M.'s training and experience qualify T.M. to interpret J.M.'s symptoms and explain that J.M. did not have a sudden onset of heart failure. T.M.'s testimony assisted the hearing officer in understanding the evidence; namely, the import of J.M.'s physical symptoms on December 3, 2002. V.R.E. 702. An earlier response to J.M.'s symptoms on December 2, 2002 may have led to earlier treatment and avoided the subsequent

heart failure and hospitalization. In addition, petitioner's testimony regarding J.M.'s condition on December 2, 2002 is not credible in light of T.M.'s testimony.

The combined impacts of petitioner's omissions on December 2 and 3, 2002 add up to neglect that placed J.M. at risk of physical harm.

Upon returning from FAHC, J.M. was given discharge orders that included new medications and an order for physical therapy. Petitioner came into possession of J.M.'s new prescriptions and the discharge order on December 7, 2002—the same day as J.M.'s discharge. As a caregiver and operator of a Level IV residential care home, petitioner had an obligation to see that J.M.'s medical needs including the provisions of the discharge order were provided.

Petitioner did not do so. In terms of the new medications, petitioner did not make sure that the prescriptions were filled although she had the original prescriptions in her possession. Further, petitioner did not ensure that J.M.'s existing medications were up to date. Two days after his discharge from FAHC, J.M. was taken to the FAHC emergency room on December 9, 2002 by petitioner because J.M. had difficulty breathing and did not have medications.

Further, petitioner did not ensure that the order for physical therapy came to fruition. On December 9, 2002, petitioner answered a call from the VNA and informed the VNA that J.M. was back in the hospital. However, J.M. was not admitted to the hospital and returned to the residential care home that same day. Petitioner did not share that information with the VNA that day. The physical therapy did not happen. On December 16, 2002, petitioner needed to help petitioner get out of the bathtub because he was too weak to do so.

The combined impact of petitioner's failure to see that the prescriptions were filled and that VNA was able to evaluate J.M. for physical therapy constitute neglect that could have led to physical harm.

As found above, credible evidence establishes that the petitioner neglected J.M. The Department's decision must be affirmed. 3 V.S.A. § 3091(d); Fair Hearing Rule No. 17.

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